

South Carolina e-forms

1296 – Long Term Care - CLTC

GAPS – senior pharmacy program



SC ACCESS
AGING AND DISABILITY
INFORMATION

www.scaccesshelp.org

E-Forms

- Available 24/7 to apply for services
- Multi-agency usage
- Makes the application process faster and more convenient for constituents
- Offers electronic benefits filing
- Eliminates traditional paper applications
- Makes applications simple to complete and easy to read
- Enables auto-population of forms by using data saved from previous forms
- eForms reduces clerical time 35-50%

If you are an adult (18+) who is aged, blind, or disabled and a resident of South Carolina, you can now submit your SC Medicaid Application online!

This Medicaid form is for **SC residents** only. It is for adults (18+) living at home **who are aged, blind, or disabled** and who need help to pay for health care services which will allow them stay in their home. It also is for someone who is living in a nursing home or is applying to live in a nursing home and needs help to pay for the nursing home care.

This form can be submitted electronically to the State DHHS Medicaid office or mailed to your local Medicaid Office. If you choose to submit electronically, you must print out the signature page and mail it to the State Medicaid office within 15 days.

NEW!! The look-back period for all transfers of resources that occur on or after February 8, 2006 has changed. Contact your local Medicaid office for details.

If you are applying for a child, a family with children, or a woman who is pregnant, [click here](#) for a simpler form that better meets your needs.

You must register (on this site) to submit your Medicaid application electronically. All residents of South Carolina who are aged, blind, or disabled may print the form and mail to the local Medicaid office for processing. In order to save your Medicaid application and be able to go back to it at a later time, you must Register.

[Fill out an online Medicaid Application form](#)

**South Carolina Department of Health and Human Services
MEDICAID APPLICATION FOR**

☐ Nursing Home ☐ Waiver Services ☐ General Hospital

County Name: _____ Case Number: _____ Date Received: _____

The following information is needed so that a determination of eligibility for Medicaid can be made. Any information given is subject to verification. At the end of this form, you will be asked to sign a statement that you understand the questions and that you have answered all the questions fully and completely, to the best of your knowledge, and that you have not given any false information. Please answer all questions unless otherwise instructed.

1. Answer these questions if you are making this application for someone else.

Your Name: _____ Relationship to Applicant: _____

Your Address: _____ Home Phone Number: _____

_____ Work Phone Number: _____

Do you or anyone else have any of the following for the applicant? ☐ Yes ☐ No ☐ Don't Know

☐ Conservatorship ☐ Guardianship ☐ Power of Attorney

If yes, please give us a copy of the legal papers and the name of the person if someone other than you.

Name: _____

2. Who is the person needing assistance (applicant)?

☐ Aged (Age 65 and older)

☐ Disabled ☐ Blind

First	Middle	Last
Home Address	Mailing Address (if different)	Home Phone Number
_____	_____	_____
_____	_____	Work Phone Number
_____	_____	_____

Where is the applicant physically located now? _____

If in a medical facility, what was the date of admission? _____

Please give the following information about the applicant:

Date of Birth (Mo/Day/Year)	Sex	SC Resident (Yes or No)	US Citizen (Yes or No)	Marital Status	Social Security Number	Social Security or Railroad Retirement Claim Number

Race: ☐ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian
☐ American/Oriental ☐ Refugee Entrant ☐ Other

Full name at birth:	Place of birth: (County and state where hospital or home in which he/she was born is/was located)

3. Give the following information about the applicant's spouse and children in the home under age 21. Also list any children in the home over age 21 with a disability.

Name	Relationship	Birthday (Mo/Day/Yr)	Sex	Race	SC Resident (Yes or No)	Marital Status	Social Security Number (Optional)	Social Security or Railroad Retirement Claim Number (Optional)
	Spouse							

South Carolina Medicaid Application

Step 1 of 12.

This Medicaid Application is for:

☐ Nursing Home

☐ Waiver Services

☐ General Hospital

Are you completing this form for yourself or for someone else who needs to apply for Medicaid?

☐ Myself

☐ Someone Else

If you are filling out this form for someone else, please tell us a few things about yourself.

Last Name

First Name

Middle Initial

Address (Where you live)

Apartment Number

City

State

Zip Code

Home Telephone Number

Work Telephone Number

Who is the person needing Medicaid?

Applicant's Last Name

First Name

Middle Initial

How are you related to the applicant?

☐ Spouse

☐ Parent

☐ Child

☐ Brother/Sister

☐ Agency Rep

☐ I, R and A Spec.

☐ Other

Do you or anyone you know have any of the following for the applicant?

Power of Attorney	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
Guardianship	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
Conservatorship	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know

If yes, give the name of the person who has authority to act for the applicant.

Please give us a copy (not original) of these legal papers.

View Terms and Definitions

Next Page

Close Form

Select Step

Go

You are currently on step: 1

The following are the terms and definitions used on the
South Carolina Medicaid Application Form.

Term	Definition
Cash Surrender Value	A form of equity value a life insurance policy acquires over time. The amount of money a person may receive if they surrender their Life Insurance Policy before its maturity or the insured's death. Gross Cash Value less any outstanding loans and surrender charges.
Face Value	Amount of basic death benefit contracted for at the time a life insurance policy is purchased.
Fair Market Value (FMV)	The amount for which property can be sold on the open market in a particular geographical area. Also called, Current Market Value (CMV).
Intent to Return Home	An individual resides with a relative, in an assisted living, or nursing facility but has the desire to return home should his health permit.
Mortgage	A pledge or security of particular real estate for the payment of a debt or the performance of some other obligation within a specified period.
Pre-need Burial Contract	An agreement whereby the buyer pays in advance for a burial that the seller agrees to furnish upon the death of the buyer or other designated individual.
Promissory Note	A written unconditional agreement whereby one party promises to pay a specified sum of money at a specified time (or on demand) to another party. It may be given in return for goods, money loaned, or services rendered.

South Carolina Medicaid Application

Congratulations! You have completed 3 of 12 steps in this application.

You can continue with the application by clicking Next Page now, or you can pause at any time by clicking Close Form and choosing the options to save the information. Please note, in order to save the information you must be logged into the system by registering yourself.

If you need help completing this form, you may call the Medicaid Eligibility Office in your area.

Go to: www.dhhs.state.sc.us/dhhsnew/DHHSCountyOffices.asp to find the phone number.

Previous Page

Next Page

Close Form

Select Step

Go

South Carolina Medicaid Application

Non-registered applicants (did not set up an account, information will not be saved and cannot submit electronically)

You may mail, fax or deliver the application in person:

- a. Print the application by selecting "Print this Form". The "official state form" will appear (in Acrobat) with the information you entered. You may click on the printer icon on the toolbar or right click on the mouse and select "print".
- b. Sign the application on page 7, on the line labeled "Applicant/Beneficiary's Signature" following the section on Estate Recovery and
- c. Mail, fax or deliver the application (with the signature page) to your local DHHS Medicaid office. To find your local Medicaid office, go to:
<http://www.dhhs.state.sc.us/dhhsnew/DHHSCountyOffices.asp>

Registered applicants: (have set up an account, information will be saved and can submit application electronically): When you submit electronically, your form is automatically saved. The option to print this form will appear after you submit the form. To mail, fax or deliver the application in person, follow the steps above.

To Electronically Submit the Application (registered users only)

- a. select "Submit Electronically"
- b. Print the application for your records (see a above)
- c. Sign the application on page 7, on the line labeled "Applicant/Beneficiary's Signature" following the section on Estate Recovery and
- d. Mail or fax the signature page (page 7) to the State DHHS Medicaid office listed below.

IMPORTANT! For electronically filed Medicaid Applications:

The signature page of the application needs to be received within 15 days of the electronic submission in order to keep the date of electronic submission as your original application date. Otherwise, the date of the application will be changed to the date the signature page is received by the DHHS office.

The signature page for electronically filed applications must be mailed or faxed to:

SC Department of Health and Human Services (SC DHHS)
Division of Central Institutional Unit
P.O Box 2364
Columbia, SC 29202-2364

Questions? Phone: 803-898-2635 or 1-888-549-0820 (toll-free)
Fax: 803-255-8350

For a list of verification documents, go to:

<http://www.dhhs.state.sc.us/dhhsnew/includes/checklists/Checklist%20for%20FM%201296%20ME.doc>

To print a copy of your application at a later date, go to
the 'My Forms' section of the site.

- ☐ Close and Save your information
- ☐ Print this form (requires Acrobat Reader version 5 or 6)



*For a list of verification documents, go to:

<http://www.dhhs.state.sc.us/dhhsnew/includes/checklists/Checklist%20for%20FM%201296%20ME.doc>

- ☐ Close and Exit the form

OK

Step 1

South Carolina Medicaid Application

PLEASE READ THIS IMPORTANT INFORMATION ABOUT YOUR PRIVACY RIGHTS

The information on this form may contain personal information such as health, financial, and identifying data that you may want to keep confidential. If you choose to continue with the option you selected, SC Access protects this information from unauthorized or unintentional access. If you have chosen to save this data, you are not authorizing SC Access to share it in whole with any third-parties for any reason. If you have chosen to submit this data to the provider, it will only be available to that provider. You have the right to choose not to save or submit this information now.

If you click Yes below it means you have read about your rights and request that the information be saved for the purposes stated above.

Are you ready to continue with the option you selected to save or submit?

Yes, I understand my privacy rights and want to continue with my selection.

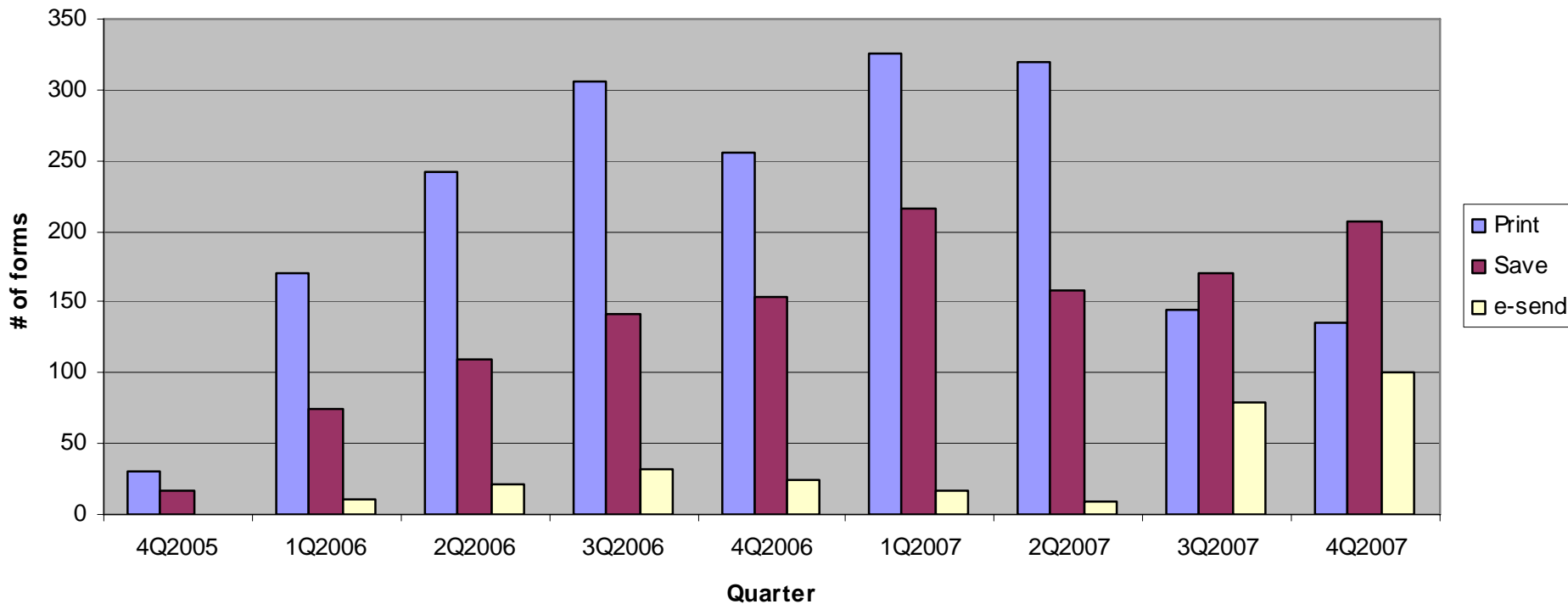
No, I want to return to the previous page so I can choose another option.

Medicaid Eligibility Frequently Asked Questions

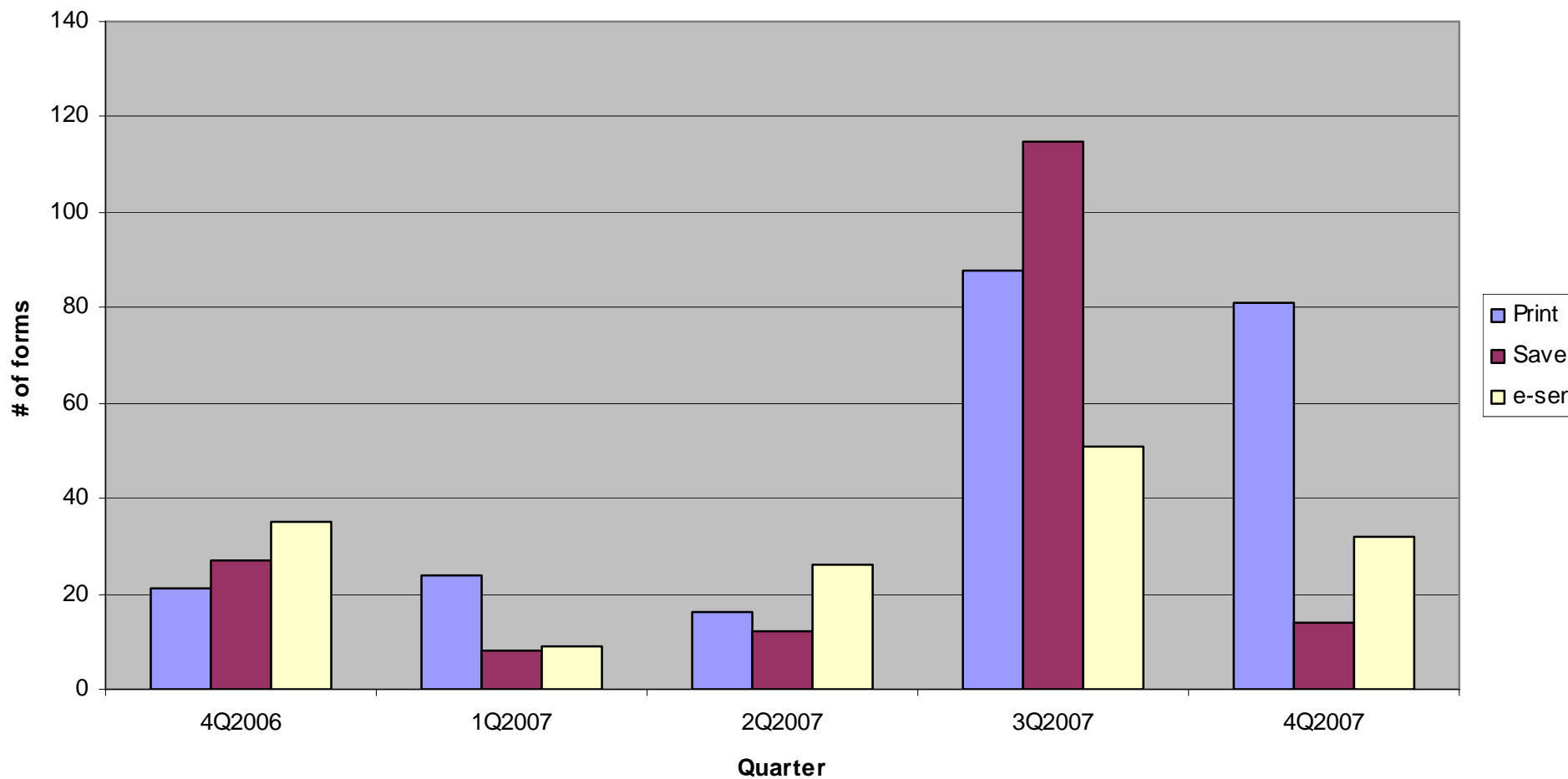
Read the Medicaid Recovery Estate Brochure

If the applicant has a disability and has not applied for SSI or SSDI, you may want to call the Social Security Office toll-free at 1-800-772-1213 to see if you are eligible.

**Medicaid LTC (1296) eform
Online 10/05
E-submit in 2 counties only
Added 4 more counties to E-submit 4/06
E-Submit statewide 7/07**



GAPS e-form went online 9/15/2006



	Print	Save	E-send	Total
1296	1930	1248	293	3471
GAPS	230	176	153	559
Total	2160	1424	446	4030

Medicaid LTC (1296) eform

Went online October 2005

E-submit in 2 counties only

Added 4 more counties to E-submit April 2006

E-Submit statewide July 2007

GAPS

Went online 9/15/06 – statewide e-submit

Future E-forms

- ABD/SLMB/QMB (DHHS)
- Medicaid for the Working Disabled (DHHS)
- Food Stamps
- DDSN
- Housing